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The experiences of women, midwives and obstetricians when women decline recommended maternity care: A feminist thematic analysis.

Bec Jenkinson,^{a,b*} B.Ed Hons. Sue Kruske,^{b,c} RN, RM, BaHSc Hons, PhD. Sue Kildea,^{a,b} RN, RM, BaHSc Hons, Grad Cert Teaching and Learning, PhD.

^aMater Research Institute, The University of Queensland, Brisbane, Australia.

^bSchool of Nursing and Midwifery, The University of Queensland, Brisbane, Australia.

^cInstitute of Urban Indigenous Health, Brisbane, Australia.

bec.jenkinson@mater.uq.edu.au

sue.kruske@iuih.org.au

sue.kildea@mater.uq.edu.au

*Corresponding author: Bec Jenkinson, Midwifery Research Unit, Mater Research Institute-UQ, Level 2, Aubigny Place, Raymond Terrace, South Brisbane, Queensland 4101. Telephone: +61 439 765 633.

Abstract

Background:

Pregnant women, like all competent adults, have the right to refuse medical treatment, although concerns about maternal and fetal safety can make doing so problematic. Empirical research about refusal of recommended maternity care has mostly described the attitudes of clinicians, with women's perspectives notably absent.

Design:

Feminist thematic analysis of in-depth, semi-structured interviews with women's (n=9), midwives' (n=12) and obstetricians' (n=9) about their experiences of refusal of recommended maternity care.

Findings:

Three major interrelated themes were identified. "Valuing the woman's journey", encapsulated care experiences that women valued and clinicians espoused, while "The clinician's line in the sand" reflected the bounded nature of support for maternal autonomy. When women's birth intentions were perceived by clinicians to transgress their line in the sand, a range of strategies were reportedly used to convince the woman to accept recommended care. These strategies formed a pattern of "Escalating intrusion".

Key conclusions and implications for practice:

Declining recommended care situated women at the intersection of two powerful normative discourses: medical dominance and the patriarchal institution of motherhood. Significant pressures on women's autonomy resulted from an apparent gap between clinicians' espoused and reported practices. Implications for policy and practice include a need for specific guidance for clinicians providing care in situations of maternal refusal, the potential value of an independent third-party for advice and advocacy, and the development of models that support reflexive practice amongst clinicians.

Keywords

hospital, maternity; treatment refusal; personal autonomy; refusal to treat; professional autonomy.

Introduction

The right to refuse medical treatment, held by all competent adults and unaltered by pregnancy status, is a central tenet of respectful maternity care (White Ribbon Alliance, 2011). It is well established in case law, midwifery (International Confederation of Midwives, 2008) and obstetric ethical guidance (FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, 2012), and health policy (Department of Health, 1993). However, research about refusal of recommended maternity care has focused on the attitudes of obstetricians (Cuttini et al., 2006; Samuels et al., 2007; Chigbu et al., 2009), and to a lesser extent, midwives (Danerek et al., 2011). These studies have often examined the use of court orders to authorise caesarean sections (CS) on non-consenting women, or been conducted in situations where dissenting women were refused care.

Although court intervention to authorise treatment on competent non-consenting pregnant women is almost unheard of in Australia, choice in maternity care remains illusory (Pilley Edwards, 2004), and willing and unwilling compliance with recommended care is commonplace (Thompson & Miller, 2014). When women resist the norm, safety concerns can lead to conflict, as clinicians can feel their own autonomy is challenged, or that the woman's preferred care is beyond their expertise (Perry et al., 2002). Ethical turmoil and clinicians' medico-legal concerns are well documented (Thompson, 2013; Biscoe & Kidson-Gerber, 2015). Inflexible maternity care that fails to meet women's needs has also contributed to rising rates of planned homebirth without skilled attendant (Dahlen et al., 2011; Ireland et al., 2011).

Only a few studies have engaged women who had (Chigbu & Iloabachie, 2007; Ireland et al., 2011), or intended to (Enabudoso et al., 2011), decline recommended care in hospital settings. These studies shed light on women's reasons for declining recommended care, but not on their

experiences of doing so. This silence around women's experiences perpetuates their marginalisation (Rich, 1995).

Reclaiming women's bodily autonomy is a longstanding focus of feminism (Rich, 1995), although largely centred on access to abortion and contraception (Weitz, 2003). Rich (1995, p13) distinguished between the experience of mothering as "the potential relationship of any woman to her powers of reproduction and to children" and motherhood as "the *institution* which aims at ensuring that that potential, and all women, shall remain under male control." This distinction, between the experience of mothering as woman-centred and potentially empowering, and the "unequivocally oppressive" (O'Reilly et al., 2005, p9) patriarchal institution of motherhood, enabled feminism to reclaim mothering while securing women "a life, purpose and identity outside and beyond motherhood" (O'Reilly, 2007, p.802).

Woman's enculturation into the institution of motherhood begins long before childbirth, with the ideal woman defined by her status as a mother (Malacrida & Boulton, 2012). As the perception that the fetus has separate rights to the woman has grown (Pollitt, 2003), the expectation of self-sacrificial motherhood has extended into pregnancy (Bristow, 2016) and even pre-conception (Clark-Flory, 2016). Although woman-centred care has become a cornerstone of progressive health care policy, there has been a shift in obstetric concern towards the fetus such that "there seems to be a point at which the value of foetal life begins to outweigh, perhaps not so much the life of the mother, but perhaps her right to self determination, her plans and her choices" (Cahill, 2001, p. 340).

Although medical control of childbirth was (and is) promoted as being about the safety of women and babies, it was (and is) a gender-based oppression (Cahill, 2001; Diaz-Tello, 2016). The medicalisation of childbirth was predicated on the incompetence and unreliability of women, whether to birth babies or to provide care to birthing women, and led to the ascendancy of obstetrics over midwifery (Murphy-Lawless, 1998; Cahill, 2001; Fahy, 2007). Women's autonomy in

childbirth has been further eroded by a culture that focusses on the short-term and trivialises women's experiences (Wendland, 2007).

In August 2010, a large tertiary hospital in Brisbane, Australia, implemented the Maternity Care Plan (MCP) policy to guide communication and documentation when women declined recommended care. The policy directs a consultant obstetrician to meet with such women during the antenatal period to discuss and document their intentions in an MCP, which is then circulated to all obstetricians and to midwifery managers. The policy recognises the woman's rights to refuse recommended care and assures them of ongoing access to care at the hospital. Our earlier studies of the MCP process found that it was used narrowly and inconsistently, and generally not created until late pregnancy, meaning most maternity care did not occur in the context of an MCP (XXXX et al., 2015). Also, while we found that the MCP process provided a symbol of respect for maternal autonomy, the larger forces of patriarchy and medical hegemony remained largely unchallenged (XXXXX et al., 2016). Such findings highlighted the opportunity for a feminist analysis of the experiences of women, midwives and obstetricians when women decline recommended maternity care.

Methods

In-depth semi-structured interviews with women, midwives and obstetricians provided data for a feminist thematic analysis of interview transcripts. The study was led by a steering committee involving the three authors, as well as obstetric and midwifery leaders from the study site.

Interviews were facilitated by the first author, on some occasions jointly with the second author or another academic advisor (as part of the first author's doctoral studies). The first author is not a clinician, but has worked extensively as a maternity consumer representative and advocate in Australia. The other authors are both midwives, working in both academic and clinical contexts. The study was approved by hospital and university ethical review committees.

Participant selection and recruitment

The database of MCPs was used to identify potential women participants (n=52). These women's charts were audited for consent to be contacted about research, and consenting women (n=16) were invited to participate, by letter. Midwives and doctors who had provided care in the context of MCPs and obstetricians who had authored MCPs were recruited via email invitation from hospital managers and information sessions provided by researchers.

Data collection

Interviews followed feminist principles (Oakley, 1981) and were guided by open-ended prompts about refusal of recommended care (see Table 1). Transcription and preliminary analysis occurred concurrently with interviewing, and all individuals who expressed interest in the study were interviewed. Data saturation was observed in each participant group. Most interviews were individual and face-to-face. Three interviews occurred in small groups, involving 2 midwives, 2 obstetricians and 4 obstetric registrars respectively. Two interviews occurred via telephone at participant request. Interview times and locations (hospital, participant's home or community location) were nominated by participants.

Table 1: Open-ended prompts for interviews

Clinicians	Women
<ul style="list-style-type: none"> What aspects of recommended care do women sometimes refuse? How common do you think it is? Is that changing? Why do you think they refuse? What are your reactions or concerns when women decline recommended care? 	<ul style="list-style-type: none"> Tell me about your recent maternity care. What aspects of recommended care did you prefer to avoid? Why was that important to you? Who did you express your birth intentions to? What happened after that?

Data analysis

Interviews were audio recorded, transcribed verbatim and anonymised before uploading to NVivo (QSR International, 2012) for thematic analysis guided by Braun and Clarke's six step approach (Braun & Clarke, 2006). The first and second author jointly read a selection of transcripts to create an initial coding scheme, which the first author used to code remaining transcripts, with adaptations made to accommodate new ideas. Coding proceeded iteratively, grouping related comments into themes. Further reading within themes and whole transcripts included searches for disconfirming data, and enabled themes to be clarified, with some sub-divided and others merged until stable themes were tentatively labelled and defined. All three authors independently reviewed data within each theme. Minor adaptations were made by consensus, until stable themes were agreed by all.

This study's overall goal was to informing change in maternity services, and it was therefore strategic to adapt Braun and Clarke's (2006) approach describe above by conducting two iterations of the qualitative analysis. The first iteration took a descriptive approach (reported elsewhere, see XXXXX, 2016) and focussed on participants' experiences of the MCP process. That descriptive thematic analysis was not, however, intended to foreground the underlying values, attitudes and behaviours that influence the provision of maternity care in such situations. Rather, a second iteration of thematic analysis was undertaken with a feminist lens and focussed on participants' broader comments about refusal of recommended maternity care (the focus of this paper).

Adopting a feminist approach foregrounded issues of power and dominance, and underpinned engagement with the viewpoints of marginalised participants. This iteration of the analysis therefore inverted the hierarchy traditional in medically-dominated maternity settings, privileging the experiences of women over clinicians, and the experiences of women and midwives, over obstetricians. This approach has provided insights that could contribute to both the literature on treatment refusal in maternity care, and to the feminist goal of recovering and valuing women's experiences (Rich, 1995). It also attends to an apparent gap in midwifery research, where feminist

approaches have rarely been reported (Walsh et al., 2015), and recognises that women's stories "were never mere anecdotes, but testimony through which the neglect and abuse of women by the health care system could be substantiated" and change wrought (Rich, 1995, p. xi).

In this paper, quotes are attributed to participants identified by group (MW for midwives, OB for obstetricians, W for women) and an individual (eg MW3, OB5 etc). Numbers were allocated upon invitation, and therefore do not correlate with the number of participants. Where needed for clarity and brevity, words have been inserted into quotes (denoted by [square brackets]) or omitted (denoted by ...). Reported speech is indicated by inverted commas. Throughout this paper, the term "clinicians" refers to obstetricians and midwives collectively. Clinicians are not distinguished by gender or position since doing so may have made individual participants identifiable. Also, clinician gender was not the focus of this analysis since the oppression of women in maternity care is gendered, not by the gender of the oppressor, but by the gender of the oppressed (Diaz-Tello, 2016). The medicalisation of pregnancy and birth can be seen as a "system of care designed for the comfort of the men who control the services, rather than for the women they serve" (Murphy-Black, 1995). Murphy-Black's notion of "comfortable men" doesn't refer to just males or obstetricians, but to those (regardless of gender or profession) that have been enculturated into contemporary medicalised maternity care.

Results

Participants

Thirty individuals were interviewed: nine women, 12 midwives and nine obstetricians. Women had a median age of 33 years. All of the women were partnered, living in an urban area, of Caucasian ethnicity and English speaking. Most (n=7/9) were tertiary educated and multiparous (n=7/9). All had singleton pregnancies, and all infants were live born. During their maternity care, seven of the women had declined caesarean sections (CS), in the context of at least two previous CS (n=5) or

breech presentation (n=2). Two women had declined continuous monitoring of the fetal heart during a planned vaginal birth after one CS (VBAC1). One woman also declined induction of labour after 42 weeks gestation. Most had vaginal births in accordance with their documented plan (n = 6); two consented to CS during labour. One woman chose not to birth at the study site, while two others had previously been refused care in other settings due to their birth intentions. The women were between two and fourteen months post-partum when interviewed. Obstetricians and midwives were all employed in clinical roles at the study site. Obstetricians ranged from being in their first year of specialist training to more than 20 years consulting experience. Midwives ranged from at least 10 years to more than 40 years midwifery experience and were all employed in clinical roles at the study site. Interviews had a median duration of 52 minutes, during which participants recounted their experiences both at the study site and in other settings.

Themes

Three major interrelated themes were identified (Figure 1). Theme one, “Valuing the woman’s journey”, encapsulated care experiences that women valued and clinicians espoused. The second theme, “The clinician’s line in the sand” reflected the bounded nature of support for maternal autonomy. When women’s birth intentions were perceived by clinicians to be across this line in the sand, a range of responses, escalating in intrusiveness, were reported. This pattern of “Escalating intrusion” is captured in the third theme.

[Insert Figure 1 about here]

Valuing the woman’s journey

This theme including the subthemes: “just wanting to try”, “understanding the woman’s whole context” and “relationships are key.”

Just wanting to try

Women often described refusing recommended care as “just wanting to try.” This included having a “very graded” (W11) plan to respond to specific indications in their own labour and birth, rather than accepting interventions in advance.

If there was going to be ... something go wrong, I was gonna go have a caesarean... I wasn't going to be stupid, I just wanted ... to try. (W16)

Clinicians' reported being sensitive to women's desires to attempt her preferred birth and universally acknowledged that it was “extremely, extremely rare” (MW1) for a woman to expose the fetus to excessive risk.

[Women] just want... to be heard and know they were listened to, and just try. (OB2)

No women rejected medical intervention entirely. Rather, they sought flexibility and valued talking about alternatives in order to identify options they found acceptable.

It was really talking through with me ... all of these different risks and looking at different decision points... Going through step by step what might happen and agreeing whether I would be ok or not with that. (W5)

The women valued balanced discussions of risk information, contextualised in their own situations.

I felt the information I was being given was both sides... I can't handle that thing where they talk about ... the risks of a vaginal birth, but what are the risks of a Caesar? (W11)

Understanding the woman's whole context

Women's motivations for declining recommended care were diverse. They attributed their birth intentions to viewing vaginal birth as a rite of passage; wanting to avoid specific experiences encountered in a previous birth; reduced recovery time from vaginal birth over CS, especially in the context of caring responsibilities for older children; desire to maximise the likelihood of a normal

birth; belief that vaginal birth would enable easier and swifter bonding with new baby; wanting baby to be born when it was ready (rather than labour being induced), and wanting future pregnancies not to be complicated by multiple previous CS.

Some midwives described how understanding the woman's broader social world helped them to understand and respect her refusal.

She's a mother of four and there's no man on the scene and there is no one that she can say, "look after the kids I've got to go to the hospital and stay there for days"... She didn't want a caesarean because she needed to drive her kids to school, ... do the shopping and the cooking. (MW12)

Although understanding the rationale behind refusals was regarded as ideal, clinicians reported that it was rare for this information to be noted, creating a simplistic picture of women's needs.

The notes say patient declined blood test in pregnancy, so I said "... Are you scared about the needles [or] are you worried about the pain, just physically [or] what it looks like?" [The woman replied] "I don't want to look at it and I'm worried about the pain..." So ... how about if we put Emla cream on the arm and you look away ... will you have it then? And she said yes ... But the notes say, patient declined. End of story. (OB2)

It was uncommon for doctors to reveal insight into the complex circumstances influencing women's decision-making. Instead, they tended to encapsulate the woman's motivation as pursuing a particular birth experience.

I don't really... understand why there is so much emphasis on the actual experience. To me, it seems to be at the expense sometimes of safety. (OB5)

Conversely, both women and midwives were likely to value the birth experience as an outcome in its own right.

There are always situations where a woman will do something that I wouldn't do, but it's not my journey. It's only one woman that is going to give birth in that birth room. (MW11)

[Wanting a VBAC3] just stems from that second pregnancy of feeling bullied and ripped off... I guess having caesareans, I hadn't gone through that birthing process... I'd missed out on a really good experience. (W16)

Relationships are key

Clinicians emphasised the importance of building trusting relationships with women, but acknowledged that this was challenging in a busy public hospital.

It all comes back to relationship... if she feels like she is respected and listened to... I don't think [we] put enough emphasis on ... relationship building. (MW11)

Midwifery continuity of carer was regarded as a way of developing these trusting relationships.

[The women had] a relationship with that midwife and so they had worked out a lot of ... what they wanted in a way that actually was sometimes not quite so ... risky. [But if] there is no continuity, and there's very little trust ... and there's no relationships. And it's very difficult. (OB5).

The clinician's line in the sand

All clinicians espoused respect for women's autonomy, but invoked a "line in the sand" that bounded their practice and the perceived reasonableness of women's choices. Although both doctors and midwives alluded to boundaries, midwives were most likely to acknowledge them explicitly. The circumstances perceived as crossing the "line in the sand" appeared to depend on the clinician's profession and temperament, as well as characteristics of the woman and her birth intentions.

Although all clinicians espoused respect for women's autonomy, many reported experiencing internal conflict when they feared a woman's choices might adversely affect the fetus.

A woman has the right to make any call regarding her health, or the health of her pregnancy or the baby. (OB1)

It's a double-edged sword isn't it in some ways? That's that woman's baby and her body and she can do whatever she likes.... But ultimately, that baby is kicking around and moving ... it's the potential life ... I really struggle with that. (MW2)

In practice, this meant that most clinicians described boundaries set by the perceived reasonableness of the woman's birth intentions. Midwives often expressed these boundaries explicitly.

As long as they're not being completely outrageous. You can't advocate for things that ... are so far off the spectrum, it's ridiculous. (MW8)

Conversely, doctors often denied the existence of a "line in the sand", with some suggesting that they were unfairly cast as the villain, and that concerns about their respect for maternal autonomy were baseless.

You get the impression from women that doctors are bad... You get that sort of passive aggression sometimes from them [women]... They have that idea that the doctor's just going to say no. (OB2)

However, there was slippage in doctors' talk on this topic. The quote above indicates obstetricians' acceptance of their own role as authorising women's birth intentions, while another doctor suggested that support was available for things that were perceived to be only "a little bit different" (OB5) and "not really unsafe" (OB5). In other circumstances, the possibility remained that the doctor's roles might be to "lay down the law" (OB5).

We're not here to ... lay down the law ... We are here to say... if you want to ... do something that is a little bit different, but it's not really unsafe, then go for it. (OB5)

The perceived reasonableness of a woman's choices appeared to depend on her stage of pregnancy, the duration and circumstances under which she persisted with her refusal and perceived risk to the fetus. The first quote referenced in this subtheme (above) revealed how a fetus near term was accorded greater standing in the mind of the midwife. Similarly, declining induction of labour after 42 weeks gestation was regarded as particularly confronting.

[A woman] didn't want to be induced... she was about 3 and a half weeks over [and] ... she had some very threatening statements made to her, like "well it's ok if you want your baby to go to heaven." (MW9)

In some cases, the woman's characteristics also appeared to influence clinicians' responses to her refusal.

I had another lady who was a VBAC who was a qualified midwife and she didn't want monitoring, didn't want a cannula and I was kind of ok with that, so ... it perhaps depends on the personality as well. (MW2)

Variability within and between clinicians

Both within an individual clinician and between clinicians, the circumstances perceived as crossing the "line in the sand" appeared to vary. Women and midwives perceived that the different professional groups exhibited differing levels of support for maternal autonomy, although the skills and temperament necessary to discuss these topics with women were not universal in either profession.

We [midwives] know which doctors are or are not [supportive of women who refuse recommended care]... So we can make sure that she sees a different doctor (MW10).

It really becomes a dividing line between the midwives who do and the midwives who don't. There are those who just kind of ... "I come to work, I want to do my job, I want to work by the policies, I'm not comfortable working outside that"... whereas for others it's ... all part of the job. (MW1)

Women often became aware of this variation and accounts of conflicting advice were common.

Nearly everyone had a different statistic... [The risk of uterine rupture was described as] under 1% to start with, and then it ended up being like 15-20%, or something... I just kind of drifted off, I wasn't listening. (W16)

Clinician's previous experience was also widely regarded as determining their response to refusal of recommended care. While having had more experience was regarded as enabling clinicians to have more nuanced discussions with women, recent negative experiences could also lead clinicians to take a more risk-averse stance.

I think at the consultant level, we're a lot more cool with it, because I think we know that... we can handle it. Whereas I think the registrars tend to be very, a bit more black and white. (OB3)

The younger midwives are often very nervous. Some of the older midwives have seen horrendous situations, that then influences both of their behaviour in the same way (MW6).

There were also accounts of midwives ensuring women saw clinicians known to be more amenable.

The midwife ... said "You don't really want to see the doctor that's on at the moment, but the one that comes on at 2 o'clock, you probably want to see" [to discuss declining a repeat CS]... She hid me in a room... We waited in there for three hours. [Then the doctor]... came straight in to see us, had a look at the chart and obviously she had already talked to him and he was just lovely. (W2)

Escalating intrusion

When women's birth intentions were deemed to cross the "clinician's line in the sand", a range of increasingly intrusive clinician responses were reported. This escalation is captured in the following subthemes: "manipulation", "punishment and judgement", "badgering" and "assault".

Manipulation

Some women felt manipulated into consenting to recommended care. This could occur when intervention was presented as urgently necessary, which women perceived excluded them from decision making.

They [were] making all of these decisions for me... I should have asked to hop up and walk around for a while, take 5 minutes... re-check the baby... But instead I just agreed to be rushed off for an emergency caesarean which ... probably wasn't necessary. (W2)

In other cases, women reported that risk information was misrepresented in order to convince them to comply, with the risks of interventions such as IOL and CS downplayed and relative (rather than absolute) risks cited.

I was told continuously [that] if my baby went past forty-two weeks, I was going to double the risk of my baby dying [and] that there is no risk with an induction [for a VBAC]. Her exact words were: "The only risk with an induction is maternal discomfort." (W12)

The picture I was drawn by the doctor [about the risks of VBAC2] was that it probably would be ok, but he couldn't go by anything because there weren't enough studies done on my situation to ensure that it would be fine... they said, to be completely safe would be to have a caesarean. (W1)

Women could also be manipulated when midwives co-opted them to help the midwife by accepting recommended care.

I said to her [a woman] "For me to be your advocate, I need a lot of information... I know you don't want to have a vaginal examination, but ... I need all the information I can get. So can I do a vaginal examination and can we do a CTG for a little time? (MW5)

Punishment and judgement

There were also accounts of punishment and judgement directed towards women who declined recommended care. In both clinicians own descriptions of women, and in the reported speech of colleagues, very negative labels were prominent: "aggressive" (MW6); "stupid" (MW11); "crazy" (W1); "completely bonkers" (MW9); "asking for trouble... naughty" (MW8); "selfish" (MW11); "ridiculous... she's nuts" (MW2); "control freak" (OB4); "manipulative" (OB9). The most frequent judgement was to question whether women who declined recommended care were acting as good mothers.

I just can't quite get it ... I still can't think why I would put my experience before the brain of my child. (OB5)

My partner was walking past the desk and the staff ... [were] gossiping about [us] "oh these bloody women... it's all about their experience ... not the safety of their baby" ... We laughed about it afterwards... because... as if you've got more vested in my baby than I do! (W11)

Women's perceptions of this punishment and judgement ranged from feeling as if they were an inconvenience to being aware of more explicit condemnation.

*I ... get the impression they just want things to go smoothly, so it's easier for them... They **probably** do care, about patients. (W16, woman's emphasis)*

It really did feel... like I was being punished for not following her advice... for daring to plan a VBAC at 43 weeks with a "ginormous" baby. (W12)

He [doctor] told me that I was crazy going for a normal one after [2CS]! (W1)

Midwives also gave accounts of both midwives and doctors abandoning women as a kind of punishment.

She was almost 42 weeks and one day [and had declined induction of labour], and I went to ... discuss it with a consultant ... and the response [from the consultant was] "No... I don't recommend any surveillance of this baby. She'll come back with a dead baby." (MW11)

Say... [a woman's] had two previous Caesars and wants intermittent dopplering... and [the midwife is] sitting down there at the desk because... [the woman] doesn't really want any monitoring. Well that doesn't mean she wants to be left alone! That's not what she was asking for! ... There's a lot of washing your hands of her [the woman]. (MW8)

For women, being refused care was the ultimate form of abandonment. Two women reported being refused care due to their birth intentions.

[It was] devastating... I couldn't understand why he [private obstetrician] agreed to it [intermittent monitoring for VBAC] verbally and then later sent me a letter [withdrawing care]... I felt like a child, because I ... hadn't been given right of reply, there was no negotiation, all the decision was made by him. [W11]

Some midwives also reported feeling punished and judged by both medical and midwifery colleagues when providing care to dissenting women. They spoke of feeling "out on a limb" (MW1) and of "being blamed" (MW4) for women's refusals. Battle metaphors like "running the gauntlet" (MW1) were also common.

But [the midwife] still got an ungodly bullocking [after a woman declined active management of the third stage of labour]... She got roasted and toasted... It was just the fact that [the midwife had] deviated from what is standard practice and standard practice is synton at the time of birth. (MW8)

You are on your own... Not only have I got to fight the doctors, but I've got to fight the [other] midwives as well. (MW5)

Badgering

Repeated and prolonged discussions of risk during both antenatal care and labour could also amount to “badgering” (W13) as women could be “railroaded” (MW2) into recommended care, either within a single consultation or over time.

The obstetrician ... was just not going to ... let me ... leave the appointment until she had ... it [repeat CS] booked... She was like a little terrier. She wasn't going to let it go. (W2)

The obstetrician came in and started badgering me, telling me “your labour is just going to be like your first, you’re not going to be able to do this, you should just go for a Caesar now, why put yourself through all of this trouble” (W13).

Telling women that their baby could die was often the end-point of this badgering.

I said to my midwife that I was still not comfortable with an induction... [she] got the head of obstetrics to come in ... his exact words were: “You seem to want a vaginal birth more than you want a live baby” ... To be honest... I was surprised I got to forty-two plus four before they pulled that. (W12)

Midwives agreed that the net effect of repeated counselling could be coercive, while most doctors seemed to equate coercion only with assault or withdrawing care.

I don't think it [repeated rounds of counselling about risk] ever becomes coercive, because if we don't say no... we don't coerce them. (OB2)

Assault

The final escalation in response to maternal refusal was threatened or actual treatment without the woman's consent: Assault. Two women reported being told that recommended care would be performed, with or without their consent.

[The doctor] got really defensive and angry and raised his voice and said ... "you need to know that if you come in in labour, this is what's going to happen" [intervention which the woman had declined]. Which essentially is like a threat. That's assault. (W3)

Clinicians also recounted their own experiences of treatment being performed without consent.

[I asked a woman who was refusing CS and induction to] just come in and let us do a blood test, check your blood pressure, do a CTG... [then] that CTG shows the baby is dying and they rush her off to theatre [despite her continuing refusal]... The obstetrician ... said "I'm willing to stand up in court for this one." (MW12)

I practically assaulted someone last week... She was screaming with her legs together [saying] "No, no one's touching me" ... In reality, she never ever really gave consent, but... we just had to examine her. (OB8)

Discussion

Woman-centred care is a widely touted gold standard in maternity care, requiring care to focus on the individual woman, incorporating not just her physical needs, but also her social, emotional, psychological, spiritual and cultural wellbeing (Leap, 2009). However, this feminist analysis of the experiences of women, midwives and obstetricians when women declined recommended care identified significant pressures on women's autonomy. Although most women described some maternity care interactions which they perceived as supportive, all reported some degree of intrusion. Only one woman's account of her birth experience comprised almost exclusively of

experiences reflective of 'valuing the woman's journey.' Close examination of that case confirmed that her particular clinical circumstances and a continuing relationship with her care providers, likely provided reassurance and prevented recourse to intrusive measures. That is, this case confirmed the veracity of the themes presented above.

These pressures on women's autonomy arise because declining recommended care situates the women at the intersection of two powerful normative discourses: medical dominance and the patriarchal institution of motherhood. When women's birth intentions were perceived by clinicians to transgress the ideals of motherhood, a range of strategies reasserting clinician authority were reportedly deployed. There was variation between individual clinicians and between professional groups about just when a woman's birth intentions crossed this line, but influences related to the woman's characteristics, proximity to term, perceived risks to the fetus were shared. These negative judgements of women were often made explicit.

Mothers and fetuses

The women in this study resisted patriarchal norms of motherhood as, amongst other things, self-sacrificing and reliant on expert advice (Rich, 1995), however they remained sensitive to the social value and esteem accorded to mothers and did not want to be seen to be doing "anything stupid" (W16). This perhaps reflects the women's awareness of the judgements made about them. Beyond that, it is only by dismissing their own experiences and being seen to prioritise fetal wellbeing, that women secure permission to give voice to their own experiences of, and desires for, birth (Schiller, 2015). O'Reilly (2006) argues that feminists have become cautious, too often calling for women's emancipation to benefit children. Reliance on child-centric arguments risks trivialising women's experiences, and suggests that women's lives have only contingent value (Pollitt, 2003). Just as women who choose to birth at home may do so partly in a quest for a different kind of maternal identity (Gosden & Noble, 2000), the women in this study constructed their birth experience as

important to their own maternal identity. Reclaiming birth experiences changes women's relationship to fear and powerlessness in pregnancy, childbirth and mothering (Rich, 1995).

Clinicians in this study invoked negative judgements of women as mothers, and reported concern over fetal wellbeing. Other studies have similarly described clinicians' beliefs that they, not women, are the fetus' best advocate (Kruske et al., 2013). Although clinicians unanimously acknowledged the rarity of a woman endangering her fetus, such protestations raise the spectre of the unusual woman that would, reinforcing norms of self-sacrificial motherhood. These negative judgements reflect what feminist scholars have described as a "deep discomfort with the notion of women as self-directed social beings, for whom parenthood is only one aspect of life, as it has always been for men" (Pollitt, 2003, p.298).

The proliferation of fetal rights and the concomitant loss of maternal autonomy has been linked with the technologies of medicalisation. For example, auscultation of the fetal heart and ultrasound allow the fetus to be monitored and visualised, while the woman fades into the background (Featherstone, 2008). Likewise, the acceptance of CS into obstetric practice enabled fetal rescue despite its initially appalling maternal mortality (Murphy-Lawless, 1998; Wendland, 2007). It may be no coincidence that women's refusals in this study related to two of these features of contemporary maternity care: fetal monitoring and CS. The specific nature of these refusals challenged both the medicalisation of pregnancy and the personification of the fetus.

Risk and evidence-based medicine

It is also (at least) questionable whether the women's birth intentions really did expose their fetuses to excessive biomedical risk. The women preferred vaginal breech birth or VBAC2 over elective or repeat caesareans, or declined continuous monitoring of the fetal heart. In each case, the evidence is either contested or scant (see: Tahseen & Griffiths, 2010; Kotaska, 2011a; Rimkoute & South, 2013). These are situations which involve very small absolute risks of very poor fetal outcomes, although those risks may be more provocative when expressed in relative terms (Minkoff &

Marshall, 2016). While this constellation of circumstances is challenging (Lyerly et al., 2007), it is also clear that the “clinician’s line in the sand” does not only relate to perceived biomedical risks.

The women in this study universally refused (rather than requested) intervention. This opting-out of the obstetric model may be perceived as challenging physician authority (Cherniak & Fisher, 2008). Refusing intervention is reportedly less likely to attract supportive responses from care providers than requesting intervention (Lothian, 2006). Consistent with that, the women in this study encountered a tendency to favour intervention for fetal benefit, which extended to accounts of clinicians (over) emphasising risks to the fetus, while downplaying risks to the woman. There are (at least) two problems with this approach.

Firstly, it overlooks other considerations that the woman may prioritise, including biomedical risks to herself now and in the future, as well as psychological, social, cultural and spiritual risks (Barclay et al., 2016). Women in this study recognised the biomedical risks attending their choices, but like the Australian Aboriginal women in Ireland’s study (2011), their decisions were also calibrated against the needs of their families, their born children, and themselves. Rather than accepting the (often overstated) predictive power of risk statistics (Murphy-Lawless, 1998), the women in this study favoured “just wanting to try”, and planned to accept intervention if indicated during labour and birth.

Secondly, balancing maternal and fetal risks (even without over-emphasising fetal risks) invokes a so-called maternal-fetal conflict, pitting the woman against her fetus. This situation is more appropriately conceptualised as a conflict between the woman’s autonomy and her care provider’s judgement about fetal interests (Harris, 2000; McLean, 2009). Rather than constructing the pregnant woman as a threat to her fetus, who is then in need of rescue by paternalistic clinicians, a “wider gaze” is needed (Harris, 2000, p789). By understanding the social and family relationships, context and constraints on woman’s decision making, the pregnant woman and fetus retain their status as a single unit, with fetal wellbeing best protected by supporting maternal wellbeing (Harris, 2000;

Laufer-Ukeles, 2011). This reflects feminist understandings of autonomy as a relational, rather than individualistic, construct and underpins a broad, comprehensive and bias- and conflict-aware account of refusal (Laufer-Ukeles, 2011). This relational understanding of autonomy is captured in this study, as understanding the woman's whole context, a significant part of "valuing her journey."

Risk-averse guidelines may justifiably recommend repeat CS, CS for breech and continuous monitoring during VBAC labours, but mechanistic application of such policies is problematic (Kotaska, 2011b). In this study two women reported being refused care (at other institutions) and two reported being told that recommended care would be performed without their consent. This exemplifies "a climate of risk reduction at all costs" where "a woman's autonomy is often lost through our interpretations of the evidence and in our threat of abandonment" (Kotaska, 2007, p177). Evidence-based medicine has become a "powerful means of gender oppression" (Wendland, 2007, p.228), with refusal to accommodate alternatives to recommended care linked with both maternal and fetal deaths (Chigbu & Iloabachie, 2007; Kotaska, 2011a). Numerous scholars have called for more flexible approaches (Cuttini et al., 2006; Chigbu & Iloabachie, 2007; Ireland et al., 2011).

Proponents of evidence-based medicine argue that flexibility is at the heart of the approach, since it requires evidence to be interpreted within the context of the woman's values, goals and circumstances, relies on strong relationships between clinicians and women, and depends on communicating evidence in ways that women find meaningful (Kotaska, 2011b). That description is closely aligned with what the women in this study sought, but found lacking, in their maternity care: a balanced discussion of biomedical risks contextualised in their own unique circumstances.

Gap between espoused and reported practice

Internationally-accepted medical and midwifery ethical guidance emphasises respect for women's autonomy (International Confederation of Midwives, 2008; FIGO Committee for the Study of Ethical

Aspects of Human Reproduction and Women's Health, 2012). However, other studies have identified a misalignment between the positions of professional colleges and the opinions of clinicians' (Samuels et al., 2007), with clinicians' more likely to be influenced by personal beliefs and values (Cuttini et al., 2006; Samuels et al., 2007). This study extends such findings, by demonstrating an apparent gap between clinician's espoused respect for maternal autonomy and their reported practice.

This gap suggests that clinicians may not be aware of the influence of their own values, nor be able to make them explicit to women. This affords women little opportunity to predict how their care provider's values might influence their maternity care. This unpredictability was experienced by the woman in this study whose private obstetrician had withdrawn care late in her pregnancy, after earlier agreeing to support her planned VBAC. Moreover, both in this and other studies (Cuttini et al., 2006; XXXXX et al., 2016), there was wide variation in the attitudes of clinicians. Even where women have the opportunity to discuss their birth intentions, fragmented care means that even "carefully negotiated treaties don't turn out to be reliable" (Perry et al., 2002, p13).

Differences between professional groups

Midwives and women perceived that midwives were more supportive than doctors of maternal autonomy. Feminist and midwifery scholars link the "with woman" origins of midwifery to midwives' support for birth as a valued rite of passage (Rich, 1995; Leap, 2000). While obstetric thinking has a long history of constructing women's bodies as flawed and favouring technology and intervention, midwifery's recognition of the normality of birth is just as longstanding (Murphy-Lawless, 1998). That may account for why many midwives appeared to be more skillful and willing users of the practices encapsulated in "valuing the woman's journey", and may have drawn their own "line" further afield than their medical colleagues.

Doctors also appeared less willing to acknowledge the existence of the "line in the sand," which is consistent with the climate of denial that surrounds the problems of disrespect and abuse in

maternity care (Diaz-Tello, 2016). Such denials are part of the privilege enjoyed by Murphy-Black's (1995) comfortable men of maternity care. Doctors in this study were likely to equate coercion only with assault and withdrawal of care, overlooking the range of other experiences that, while less intrusive, still exerted great pressure on women to comply. Coercion is "a form of social power over others by which they can be made to act even if they do not wish to do so" (Lamond, 2010, p1). Although doctors tended to deny or minimize the frequency of coercion, they simultaneously described coercive practices. Soaring rates of intervention are often attributed to defensive medicine, but failures in consent processes are also significant contributors to complaints and litigation (Gogos et al., 2011), with some investigations condemning the use of "undue pressure" (Scottish Public Service Ombudsman, 2012, p7).

Midwives and escalating intrusion

Although some midwives may have been more skillful and willing practitioners of "valuing the woman's journey", they still reportedly deployed intrusive strategies. Midwives reinforce the status quo of gender, power and medicalization (Pollard, 2011) if they only reluctantly support women's choices or adopt paternalistic strategies to ensure compliance with recommended care (Jacobson et al., 2013). Participants' accounts of midwives themselves being punished suggests that recourse to intrusive strategies may also have been prompted by concerns for their own professional safety. Midwives may feel disempowered when practicing in some organisational settings, adopting the protective response of practicing "with institution", rather than "with woman" (Mander & Melender, 2009). In order to become part of the power structure, rather than resist it, a midwife may ensure her practice accords with the medicalised culture, even if doing so undermines the woman's autonomy (Mander & Melender, 2009). This phenomenon was evident in accounts of midwives choosing not to provide care to women who declined recommended care, or punishing women through abandonment. Even amongst those who continued to provide care, "doing good by stealth" (Walsh et al., 2015, p158) and manipulative strategies, such as co-opting the woman to help the midwife, were recounted. The possibility of practicing "with institution" also stems from

employed midwives' contractual obligations to adhere to employer policies (Pollard, 2005), meaning that women's autonomy is closely linked to midwives' ability to practice autonomously (Mander & Melender, 2009).

Implications for policy, practice and further research

Despite the emphasis on respect for maternal autonomy in midwifery (International Confederation of Midwives, 2008) and obstetric guidelines (FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, 2012), little specific guidance addresses maternal refusal. This study suggests that processes to guide clinicians are needed. Such processes should focus on the elements captured in "valuing the woman's journey." That is, they should afford clinicians and women the opportunity to develop trusting relationships and for clinician's to understand the woman's whole context, including meaningful communication about risk, the woman's goals and all alternative options for care. Such guidance could enable clinicians to locate their "line in the sand" further afield.

This study identified pressures on midwives' autonomy and noted the impact of these on women's autonomy. Others have argued that midwifery autonomy is maximised in freestanding birth centre models of care, but these are rare in Australia (Newnham, 2010). The eligibility criteria frequently adopted in such models of care would also exclude most, if not all, of the women in this study. The appropriateness of allowing such eligibility criteria to undermine women's autonomy is questionable (Scamell, 2014). Private midwifery models of care may overcome some of these barriers, but also remain rare in Australia and operate in a precarious regulatory framework (Wilkes et al., 2015).

An English study of midwives' experiences of maternal refusal supported statutory supervision in these situations (Thompson, 2013). Statutory supervision of midwives, although currently undergoing significant change (Department of Health, 2016), is a UK process whereby midwives are supported in clinical practice, including support for midwives' and women's decision-making and

advocacy for women whose choices diverge from advice (Read & Wallace, 2014). There is currently no equivalent to statutory supervision of midwives in Australia, although it is under consideration (Nursing and Midwifery Board of Australia, 2013). Access to an independent third-party for advice and advocacy could enable midwives to maintain “with woman” practice and avoid “escalating intrusion”. It could also provide important quality assurance that women are well informed about risks and alternatives which would help to protect women and clinicians alike.

The gap between espoused and reported practice also suggests more reflexivity is needed amongst both doctors and midwives. While reflexivity is widely embedded in undergraduate courses, it is really only explicit in the continuing practice of mental health professionals. Models need to be developed in Australia to support maternity clinicians to practice more reflexively.

Limitations

As a qualitative study conducted in one site, the findings of this study may not be readily generalisable to other hospitals, though it is important to note that some participants described experiences from other hospitals. Similarly, the views expressed and experiences recounted by the participants may not have been shared by other women, midwives or obstetricians. We also acknowledge the participants in group interviews may have answered with more or less candour than those who participated in individual interviews.

This study was limited by the recruitment of participants from one hospital where the MCP process provided at least symbolic respect for maternal autonomy. This suggests that the organisational “line in the sand” may have been more progressive than in other settings, even though the MCP process was used rarely and only for a narrow range of clinical scenarios (XXXXX et al., 2015). Further research is needed to understand whether a structured documentation and communication process can support respectful maternity care when women decline a recommended care in a range of maternity care settings. Also, the women in this study were relatively socio-economically

advantaged. Further research is needed to understand the experiences of women from a broader range of backgrounds.

Conclusion

This paper reported on a feminist analysis of women's, midwives' and obstetricians' experiences when pregnant women declined recommended care. Despite alignment between the care interactions valued (and in some cases experienced) by women and those espoused by clinicians, a range of negative interactions characterized by increasing intrusion were also reported. The demarcation between positive and negative care experiences was "the clinician's line in the sand." This mobile and implicit boundary was influenced by patriarchal conceptions of motherhood, a perception of separate fetal personhood, and medical authority.

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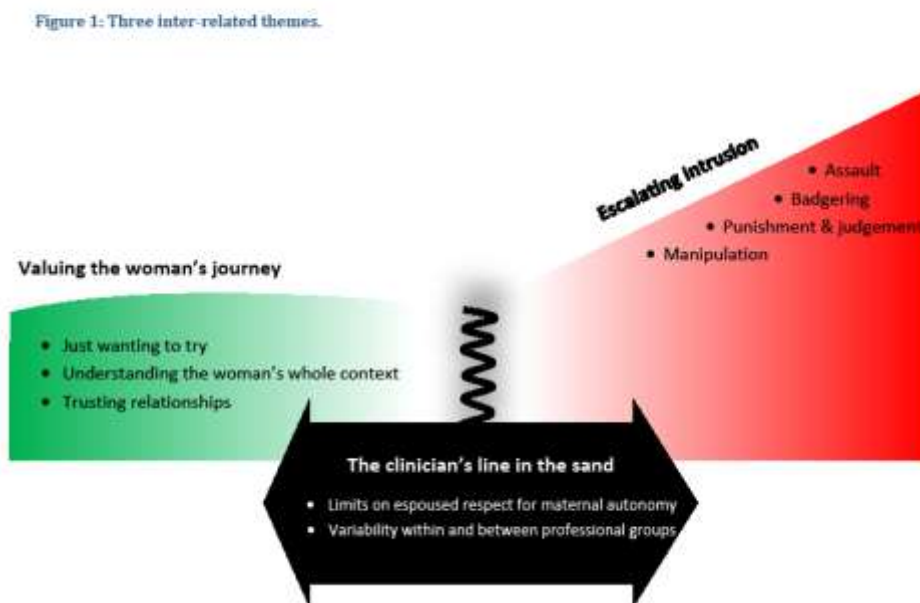
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Figure 1: Three inter-related themes.



Highlights

- Valuing each woman's journey was key to respecting right to refuse aspects of care
- Clinicians' espoused respect for women's autonomy, but women felt coerced
- Clinicians regarded "risky" birth choices as transgressing norms of motherhood
- Clinicians responses to refusals were variable and difficult for women to predict